IDAHO DEPARTMENT OF
HEALTH & WELFARE

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October 29, 2008

Joseph S. Bleymaier, Administrator
Emmett Rehabilitation & Healthcare, Inc.
714 North Butte Avenue
Emmett, ID 83617

Provider #: 135020

Dear Mr. Bleymaier:

On **September 4, 2008**, a Complaint Investigation and State Licensure was conducted at Emmett Rehabilitation & Healthcare, Inc. Marcia Key, R.N., Karen Marshall, R.D. and Diana Hall, R.N. conducted the complaint investigation. A total of 13.5 survey hours were required to complete this investigation.

- An immediate tour of the facility was conducted.
- The identified resident was observed during an activity event and during the supper meal. The resident was also observed as two staff members were provided perineal care.
- The identified resident's record was reviewed.
- Six residents' bathing records were reviewed.
- Five residents and two family members were interviewed.
- The Resident Council minutes were reviewed for May through August 2008.
- Grievances were reviewed for January through August 2008.
- Five staff members were interviewed including the administrator, Director of Nursing and one owner of the facility.

The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00003754**

ALLEGATION #1:

The complainant stated an identified resident had a pressure ulcer because the staff did not turn her on a

regular basis.

FINDINGS:

On September 4, 2008, at 2:55 p.m., the identified resident was observed during incontinence care performed by two certified nurse aides. The skin on the buttock region was intact without any evidence of pressure ulcers. One aide stated that since being employed at the facility in November 2007 she has not observed any pressure ulcers on the resident. She also stated the staff members use a barrier cream after each incontinence episode for all residents.

Review of the weekly skin checks for August 2008, revealed the identified resident did not have any impaired skin integrity due to pressure related injury.

CONCLUSIONS:
Unsubstantiated.

ALLEGATION #2:

The complainant stated that approximately two moths ago, an identified resident sustained an injury to her right ankle resulting in the inability to ambulate. The ankle was still black and blue and has not healed.

The complainant also stated the responsible party did not receive an explanation as to how the injury occurred.

FINDINGS:

The identified resident's admission Minimum Data Set (MDS) assessment, and her most recent annual MDS assessment, dated January 29, 2008, documented she was non-ambulatory secondary to her disease process.

An Incident/Accident report, dated June 6, 2008, at 8:30 p.m., documented that a staff member noticed the resident had severe bruising and swelling to her right ankle. A second staff member who had assisted the resident prior to the supper meal stated there were no observed problems at that time with the resident's right ankle.

The investigation determined the injury possibly occurred during the supper meal in the dining room. The licensed nurse on duty was counseled about monitoring residents who remained in the dining room while staff assisted other residents to their rooms.

The report documented that immediately after the injury was found, the physician and the responsible party were notified. A Diagnostic Imaging report, dated June 17, 2008, documented "...There was no fracture, dislocation or soft tissue swelling..."

The facility did not ensure the resident received proper supervision, resulting in an injury of unknown origin. This allegation was substantiated; however, the facility was not cited because the incident occurred in June 2008 one month prior to the facility's annual recertification survey on July 7, 2008, which identified at that time that the facility failed to ensure residents were properly supervised to prevent accidents. The facility was cited at federal regulation F323 during that annual recertification survey and was required to submit an acceptable plan of correction.

CONCLUSIONS:
Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated staff members were isolating an identified resident. Other residents were left in their rooms without activities.

FINDINGS:

Upon entering the facility at 2:00 p.m., an immediate tour was conducted. Many residents were on the patio and engaged in an activity. Several residents were taking naps and staff members were providing cares for other residents. Other residents who were in their rooms did not appear to be idle.

The identified resident was observed on the patio where the afternoon activity was being conducted. Although she was not actively participating, she appeared to be watching the activity. At approximately 2:55 p.m., a staff member assisted the resident to her room to provide perineal care. The aide stated the resident appeared tired, as she had also attended a morning activity.

Five residents and two family members indicated they had no concerns about the activities offered and provided in the facility.

Although the resident was actively not always able to participate due to her diagnoses, the administrator stated the identified resident was included in most activities. The administrator also stated the resident especially seemed to enjoy musical activities.

The Director of Nursing indicated that following the annual recertification survey of July 2008 the facility has greatly improved the activity program for the residents.

Because of the annual recertification survey, the facility was not cited at federal regulation F248, for failing to provide an activities program that met the needs of the residents.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the identified resident was not given food and that all meal times were distressing to the resident, especially the evening meal.

FINDINGS:

The identified resident was observed during the supper meal. Staff setup the meal for the resident and ensured she had her adaptive eating utensils. The meal appeared to be sufficient portion and nutritive value. The resident did not appear anxious or in distress during the meal.

The resident's record documented she received an enriched and fortified diet. The documentation also identified her weight remained stable from October 2007 through July 2008, ranging from 114 to 119 pounds.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated an identified resident appeared to be in pain and "hunched up." In addition, she appeared to be fearful of everything around her. The resident is unable to verbalize pain, which is not under control, especially the pain caused by the ankle injury. Staff members do not ask her if she is in pain.

FINDINGS:

The identified resident's Medication Administration Record for July and August 2008 documented the resident was on a routine pain medication, Tylenol every morning. After she sustained the ankle injury a pain assessment was performed, the physician was notified, and the resident was started on Hydrocodone for pain on an as needed basis.

Because the resident verbally was unable to communicate her pain, the staff assessed her pain through non-verbal indicators. The documentation identified the resident was assessed for pain at least each shift. She received the pain medications as indicated by her non-verbal communication.

During the complaint investigation, the identified resident was first observed attending an activity on the patio with other residents. Her upper trunk was bent slightly forward. After the activity, staff took the resident to her room and transferred her via a Hoyer lift into bed. The resident did not make any moaning sounds or facial grimaces. Additionally, incontinence care was observed to be performed after the resident was situated into bed. As the resident was repositioned in bed, she made no facial grimace and did not moan out as if in pain.

At 4:55 p.m. a staff member was observed applying lotion along the resident's right ankle region. The resident gave no indication of being in pain.

The Physician's Recapitulation Order, dated September 1, 2008, identified that as of March 16, 2007, the resident required a pommel cushion for her wheelchair for positioning secondary to a cerebrovascular accident, right hemiparesis with poor trunk control and pelvic thrust. The resident's physical appearance was due to her disease process.

The identified resident's Physician's Progress notes, dated June 18 and July 24, 2008, documented that other than the ankle injury the resident had no change in her physical or mental health status.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated the identified resident was not bathed regularly and had body odor. The resident wore the same clothes and did not get proper oral hygiene.

FINDINGS:

An immediate tour of the facility revealed each observed resident, including the identified resident, was well-groomed and wearing clean clothes. There was no obvious odor surrounding any resident. Throughout the survey, residents remained well groomed.

Six residents and two family members indicated they had no concerns about residents not getting baths, receiving oral hygiene or grooming.

The Resident Council minutes and grievances did not identify any of these concerns.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The complainant stated an identified resident's safety is compromised because staff members are neglecting her.

FINDINGS:

The identified resident was observed at random times during the survey to be either engaged in activities, receiving personal cares, being safely transferred to or from the wheelchair by staff, or in the dining room eating her supper meal.

Between 3:15 p.m. and 4:55 p.m., the resident was resting in bed. Staff members repositioned her once during that time.

The identified resident was observed to be well attended to by the staff.

The administrator stated the resident had been a well-liked member of the community and staff was very fond of her.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The complainant stated that staff members, especially on the evening shift, were unqualified and overwhelmed and did not know how to assist residents who scream and wander the halls.

FINDINGS:

During the investigation, residents were not observed unintentionally wandering the hallways.

One random resident was observed sitting in a wheelchair next to the nurses' station. She was loudly calling out. The licensed nurse and a certified nurse aide immediately approached and spoke with the resident. The resident indicated she wanted to go to the dining room. Both staff members redirected the resident to self propel herself into the dining room. The resident was observed for a brief time and did not have any further calling out episodes.

The Resident Council minutes and grievances did not identify any concerns about staff members not knowing how to assist residents who may have behaviors or who wandered the halls.

A certified nurse aide indicated in-services were provided for all staff, including watching videos. The aide also indicated the interdisciplinary team determined what approaches could be implemented to help redirect residents who required attention.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

The complainant spoke to the administrator, one of the facility owners, and a consultant about the concerns; however, the facility did not address the concerns.

FINDINGS:

The administrator stated he had received no verbal or written complaint regarding the identified resident.

One of the owners of the facility indicated she received a telephone call from one of the identified resident's family members the evening the resident sustained the ankle injury, but the person did not identify any concerns about the care the resident was receiving.

The Director of Nursing indicated that when the identified resident's family visited the facility they did not mention any concerns.

Review of the written grievances did no identify any complaints regarding the identified resident.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

As only one of the allegations was substantiated, but was not cited, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj